

STANDARD CERTIFICATE OF DEATH

State File No. 42544

10786

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY 0				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY 2229			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (in this place) 2229		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		d. STREET ADDRESS (If rural, give location) 1005 Morrison	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hosp							
3. NAME OF DECEASED (Type or Print)		a. (First) William		b. (Middle) P		c. (Last) Lynch	
4. DATE OF DEATH (Month) (Day) (Year) 12 15 50		5. SEX male 0		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2	
8. DATE OF BIRTH 6-8-1890		9. AGE (In years last birthday) 60		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) St. Louis Mo 0	
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Thomas Lynch		13b. MOTHER'S MAIDEN NAME Ottilia Hessler		14. NAME OF HUSBAND OR WIFE Louise Lynch	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. NO		17. INFORMANT'S SIGNATURE OR NAME Ottilia Huck 5511 Idaho			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) arteriosclerosis, generalized DUE TO (c) Arteriosclerotic heart disease 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 1 week 1/2 year	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 232A			
22. I hereby certify that I attended the deceased from May 18, 1950, to Dec. 15, 1950, that I last saw the deceased alive on Dec. 15, 1950, and that death occurred at 11:30 p.m., from the causes and on the date stated above.							
23a. SIGNATURE May S. Franklin		(Degree or title) M.D.		23b. ADDRESS 634 N. Grand		23c. DATE SIGNED 12/18/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12-19-50		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Mo	
DATE REC'D BY LOCAL REG. DEC 18 1950		REGISTRAR'S SIGNATURE A. B. Luster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Moydell Funeral Home 1926 Allen			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by me

working under my personal supervision.

Student Embalmer No.

Signed Dale A. Stammann

Signed.....
Student Embalmer

Licensed Embalmer No. 4533

P. O. Address St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.